

EDEBOHLS (Geo. M.)

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*With Compliments of the Author.*

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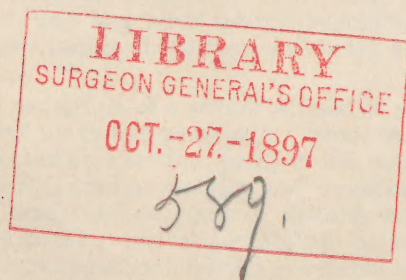
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### THREE CASES OF UTERUS BICORNIS SEPTUS; WITH REPORT OF OPERATIONS PERFORMED UPON THEM.

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CASE I. *Double Uterus; retroversion and endometritis. Cirrhosis of left ovary. Movable right kidney. Insufficiency of mitral valve. Nephrorrhaphy, curettage of uterus, unilateral salpingo-oophorectomy and ventral fixation at one sitting. Recovery.*

Katie H., aged twenty-three, single, domestic, was admitted to St. Francis Hospital, October 4, 1892. She began to menstruate at seventeen, and has been unwell regularly every four weeks since, the flow lasting three days and being accompanied by pain in the coccyx.

With the exception of a severe attack of malaria in 1882, patient was well up to five years ago. Since then she suffered from cough, dyspnea on exertion, pains in left lower chest anteriorly and posteriorly, cardiac palpitation, vomiting spells lasting for days at a time, nausea, gastric distress and eructations after meals, constipation, vesical irritability, pains in left groin, leucorrhœa and coccygodynia during menstruation. In addition she has lost flesh and become very weak, anæmic and nervous.

*Physical examination*, Oct. 11, 1892. Lungs normal. Rude systolic bruit most distinct over left ventricle and apex of heart. Spleen moderately enlarged. Right kidney movable eight centimetres in a downward direction. Left kidney cannot be palpated. Tubes and ovaries on both sides normal in size, prolapsed, non-sensitive on pressure. Left ovary very hard. Uterus enlarged in all directions, but especially the longitudinal, and retroverted in the second degree. Endometritis. Vagina, vulva, rectum and coccyx normal.

*Clinical diagnosis*: Insufficiency of mitral valve; movable right kidney; cirrhosis of left ovary; retroversion of uterus; endometritis.

The possibility of relief from many of her ills by surgical interference was presented to the patient. Such interference was advised against, however, on account of the condition of her heart.



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After considering the matter for a few days, patient demanded operation, stating that she preferred death to a continuance of her miserable condition, and that she was willing to assume any risk in the effort to regain her health.

On October 25, 1892, nephrorrhaphy, curettement, removal of the left ovary and tube, and ventrofixation of the uterus were performed at one sitting, the time required being exactly one hour and ten minutes. Ether was the anaesthetic employed.

The nephrorrhaphy for fixation of the movable right kidney offered no unusual features. At the curettement difficulty was at first experienced in introducing the uterine catheter and curette. When the instruments finally entered, the existence of two uterine cavities became evident. The right uterus measured eight centimeters and the left six and a half centimeters in depth. A strong partition, extending antero-posteriorly and reaching from the fundus to the internal os, separated the two cavities. The cervix presented nothing abnormal, except that it was a trifle large. Both uterine cavities were successively curetted and irrigated. The lower half of the septum was destroyed by the curette.

The abdomen was then opened and the retroverted double uterus examined from above. After lifting the organ out of the hollow of the pelvis it was found to be divided into two lateral halves by a linear depression, running the whole length of both the anterior and posterior surfaces and deepening into a well-marked notch as it ran over the large fundus. The right half was slightly the larger and fully equal in size to a normal single uterus. Each half of the uterus had one tube and ovary. The left ovary was small, fibrous in consistence, studded with calcareous nodules and plates, and was removed. The right appendages, being found perfectly normal, were not disturbed.

The larger and more bulging right uterus was fastened to the anterior abdominal wall by three buried silkworm sutures, embracing peritoneum, muscle and fascia.

Patient made a perfectly uneventful recovery, and left her bed on the eighteenth and hospital on the twenty-fifth day after operation, both wounds healing by primary union.

The etiology of the condition here found, the uterus bicornis septus, dates back to the third month of fetal life, development being arrested before complete coalescence of the two Müller ducts, and before complete disappearance of the line of fusion. The anterior and posterior furrows, and the fundal notch on the exterior of the uterus, and the persistent septum in its interior, permit of no other interpretation.

Uteri bicornis septi are not so rare as is generally supposed. The number of unrecognized cases is probably quite large, since the condition is likely to escape detection until either an intra-uterine encephalocele or a coeliotomy, or both, as in this instance, reveal it.

As far as the writer's knowledge goes, this is the first recorded instance of combined curettement and ventrofixation of a double uterus.

The patient was presented at a meeting of the Section on Obstetrics and Gynæcology, New York Academy of Medicine, on Nov. 25th, just one month after operation, and examined by a number of gentlemen present. A majority of her numerous previous symptoms had already disappeared.

CASE II. *Double Uterus. Curettage for Retention of Secundines after Abortion.*

The second patient was presented at a meeting of the same Section, held February 23, 1893.

Whereas in the first case the existence of a double uterus was only accidentally discovered at operation, in the second case the diagnosis was made by the bimanual touch and confirmed by intra-uterine palpation.

M. M., aged twenty-six, married. Family history good. Mother had fourteen children and two or three miscarriages. Patient herself has never been ill in her life.

Menstruation began at fourteen and has been regular and painless ever since, four days every four weeks. Her only child was born in August, 1892. A few months afterwards menstruation reappeared.

Last regular menstruation, January 1, 1893. Miscarriage on February 12; the fetus, according to patient's description of it, must have been eight to ten weeks old.

The abortion was followed by free bleeding, fever and mild sepsis, all of which continued until I first saw her on February 18, 1893; on which day the patient was etherized for the purpose of emptying and cleansing the uterus by curettage and antiseptic irrigation.

On examination in narcosis previous to operation, what was, on first impression, the subinvolute uterus was found deflected slightly to the right, with a hard globular tumor, 7 to 8 centimeters in diameter, broadly attached to its left border from a little below the fundus to the region of the internal os.

On palpation of the normal-sized ovaries and tubes, and on carefully tracing the latter, each of the tubes was found entering the outer upper portion of the mass on its own side of the pelvis. The diagnosis of double uterus was thus established.

The quite patulous cervix was dilated sufficiently to admit the index finger and a thorough digital exploration of the uterine cavity was undertaken. A strong antero-posterior septum, extending from the fundus above to very near the internal os, a distance of five centimeters, divided the uterine cavity into two fairly equal halves. The septum was thick and fleshy at its attachment to the fundus above, from which it gradually tapered



down to terminate in a tense, falciform, antero-posterior ridge near the internal os.

The right half of the double uterus was elongated in form, resembling the normal single uterus in shape, and measured twelve and a half centimeters from external os to fundus. The left half was more globular, measured eleven and a half centimeters from os externum to fundus, and evidently been the home of the fœtus. Its cavity was everywhere lined with placental remains which extended across the ridge for a small distance into the right cavity.

This case was then, like the first, one of *uterus bicornis septus*, with a pregnancy of the left horn.

Both halves of the uterus were curetted, washed with 1-2000 sublimate solution, and each half drained with its own strip of gauze leading together out of the common cervix.

Patient made an uneventful convalescence and was discharged three days later.

CASE III. *Double Uterus. Tubal and Peritoneal Tuberculosis. Total Extirpation of Uterus and Adnexa. Recovery.*

B. C., aged 26, married for a little over a year, consulted me Dec. 5, 1893, at the advice of her family physician, Dr. P. J. Lynch. Her father died an accidental death; her mother, three brothers and one sister were alive and well; one brother died of pulmonary phthisis.

The patient herself had been well up to two years ago, when leucorrhœal discharges, frequent metrorrhagia, and bearing down pains made their appearance. A year and a half ago her uterus was curetted by a gynecologist, following which the above symptoms disappeared. According to her statement she was not informed at the time that any abnormality of the uterus existed. A year later, *i. e.*, six months ago, her former troubles reappeared, together with great pain in back and both inguinal regions.

When first seen by me she presented a delicate, though not a cachectic appearance. The only thing alarming about her general condition was an intermittent pulse, one pulsation in about twenty being imperceptible. The pulse rate was seventy-two, and the heart sounds were normal in every respect. Examination of lungs negative; spleen enlarged.

On bimanual examination the uterus and its adnexa were found pretty well filling the pelvic cavity. The uterus was large, retroverted in the second degree. An unusual width of the corpus uteri first attracted attention. On closer palpation a median furrow, running the entire length of the corpus uteri on its anterior and posterior surfaces, and indenting the fundus as it ran across it antero-posteriorly could be plainly recognized. The appendages could be felt as indistinct masses packed in between the broad uterine body and the lateral pelvic walls; their exact condition could not be made out. This much, however, was



learned that they originated from the extreme upper and outer corners of the uterine mass on either side ; that part of the fundus adjacent to the median furrow was perfectly free and rounded. The cervix was large, but presented no abnormality except erosion due to endometritis.

The diagnosis of double uterus was thus made by palpation alone. On the following day curettage of the uterus was performed, and the diagnosis confirmed. A median septum, thick near the fundus, and thin at the internal os, divided the cavity of the uterus into two lateral halves, the lower end of the septum reaching to within two centimeters of the os externum. The cavity of the left uterus measured eight centimeters, that of the right a little more in depth. Both cavities of the *uterus bicornis septus* were thoroughly curetted and douched with 1-2000 sublimate solution.

On Dec. 12, 1893, coeliotomy was performed for the purpose of lifting the heavy retroverted uterus out of the pelvis and of attaching its fundus to the anterior abdominal wall. On opening the abdominal cavity the visceral and parietal surfaces of the peritoneum were found everywhere studded with fresh miliary tubercles, as well as here and there a few in more advanced stages of degeneration. The large, broad, double uterus was fastened in retroversion by adhesions. The tubes were enlarged to a diameter, at the widest parts, of two centimeters ; their walls were hypertrophied ; their abdominal ends firmly sealed and imbedded in adhesions, deep in the pelvis, behind the uterus. Both ovaries were large. The peritoneal surfaces of tubes, ovaries and uterus, but especially of the tubes, lodged a number of miliary tubercles.

Total extirpation of the uterus and its adnexa was immediately decided upon, and after liberation of the organs from adhesions, carried out after the method described by me in the *American Journal of Obstetrics*, Vol. XXVIII, No. 15, 1893. The entire double uterus, both tubes and ovaries, were removed in one piece, without rupture of either tubal sac. The operation proved unusually difficult on account of the universal adhesions, and on account of the small space left outside of the broad uterus, which made ligation of the broad ligaments anything but an easy task. The peritoneal wound at the bottom of the pelvis was closed by a running Lembert suture of catgut and the abdominal wound united throughout, without irrigation and without drainage.

Following operation the pulse was intermittent and remained so for five days:—at its worst, an intermission every third beat ; at its best, three intermissions to the minute. The normal frequency, 70 to 85 per minute, was maintained. A slight catarrhal pneumonia, involving the lower right lung posteriorly, developed on the sixth and persisted until the eleventh day. With these exceptions, a good convalescence.

Abdominal wound healed by primary union. Patient left bed

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on the fifteenth and hospital on the twenty-eighth day after operation.

On discharge abdominal wound and wound of vaginal vault firmly healed. No exudate anywhere in pelvis.

*Lungs.* At left apex posteriorly high percussion note and rude vesicular respiration; no rales. At middle of left lung posteriorly, over two small areas, broncho-vesicular, high-pitched respiration. At sternal edge of middle of right lung anteriorly, a slight friction sound.

*Heart* normal. No more intermission of pulse.

*Spleen* considerably enlarged. Patient looking and feeling well. (Patient and specimen presented.)

Dr. George C. Freeborn, pathologist of the Society reported upon the specimen. On microscopical examination he found the case to be one of primary tuberculosis of the tubes with secondary general peritoneal tuberculosis. On opening the tubal sacs he found them filled with a large quantity of cheesy material and detritus and a small amount of pus.

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